

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0039255</u></p> <p>Facility Name: <u>PARK RIDGE CARE CENTER</u></p> <p>Address: <u>665 BUSSE HIGHWAY</u> <u>PARK RIDGE</u> <u>60068</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(847) 679-8219</u> Fax # <u>(847) 679-7377</u></p> <p>IDPA ID Number: <u>36-3923246</u></p> <p>Date of Initial License for Current Owners: <u>12/01/93</u></p> <p>Type of Ownership:</p> <table> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve N. Lavenda</u> Telephone Number: <u>(847) 236-1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="3">Paid Preparer</td> <td>(Print Name and Title) <u>MARVIN FOX, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> <tr> <td colspan="2"> <p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p> </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u>	(Date) _____	Paid Preparer	(Print Name and Title) <u>MARVIN FOX, C.P.A.</u>	(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	<p>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	
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Facility Name & ID Number PARK RIDGE CARE CENTER# 0039255 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>46</u>	Skilled (SNF)	<u>46</u>	<u>16,836</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>46</u>	TOTALS	<u>46</u>	<u>16,836</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,089</u>	<u>5,133</u>	<u>870</u>	<u>16,092</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,089</u>	<u>5,133</u>	<u>870</u>	<u>16,092</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.58%D. How many bed-hold days during this year were paid by Public Aid?
80 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 12/01/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/01/93 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 46 and days of care provided 231Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **PARK RIDGE CARE CENTER** # **0039255** Report Period Beginning: **01/01/00** Ending: **12/31/00**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	A. General Services											
1	Dietary	143,009	5,737	180	148,926		148,926		148,926			1
2	Food Purchase		75,377		75,377	(564)	74,813	(1,958)	72,855			2
3	Housekeeping	71,623	15,823		87,446		87,446		87,446			3
4	Laundry	20,721	9,047		29,768		29,768		29,768			4
5	Heat and Other Utilities			28,228	28,228		28,228		28,228			5
6	Maintenance	32,227	16,138	14,736	63,101		63,101	1,838	64,939			6
7	Other (specify):*											7
8	TOTAL General Services	267,580	122,122	43,144	432,846	(564)	432,282	(120)	432,162			8
9	B. Health Care and Programs											
9	Medical Director			6,150	6,150		6,150		6,150			9
10	Nursing and Medical Records	576,642	54,245	23,202	654,089		654,089	(1,139)	652,950			10
10a	Therapy		2,590	448	3,038		3,038	(2,590)	448			10a
11	Activities		7,023	1,000	8,023		8,023		8,023			11
12	Social Services			3,588	3,588		3,588		3,588			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	576,642	63,858	34,388	674,888		674,888	(3,729)	671,159			16
17	C. General Administration											
17	Administrative	70,124			70,124		70,124		70,124			17
18	Directors Fees											18
19	Professional Services			38,026	38,026	(46)	37,980	(282)	37,698			19
20	Dues, Fees, Subscriptions & Promotions			20,381	20,381		20,381	(14,708)	5,673			20
21	Clerical & General Office Expenses	72,788	30,200	23,817	126,805		126,805	(7,438)	119,367			21
22	Employee Benefits & Payroll Taxes			114,727	114,727	564	115,291		115,291			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,090	1,090		1,090	(75)	1,015			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			22,956	22,956		22,956		22,956			26
27	Other (specify):*											27
28	TOTAL General Administration	142,912	30,200	220,997	394,109	518	394,627	(22,503)	372,124			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	987,134	216,180	298,529	1,501,843	(46)	1,501,797	(26,352)	1,475,445			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

PARK RIDGE CARE CENTER
0039255
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #

22	EMPLOYEE BENEFITS	<u>564</u>
2	FOOD	<u>564</u>

To reclass cost of employee meals from raw food to employee benefits

<div>33</div>	REAL ESTATE TAX	<div>46</div>
<div>19</div>	PROFESSIONAL FEES	<div>46</div>

To reclass cost of appealing real estate taxes

Facility Name & ID Number **PARK RIDGE CARE CENTER** #0039255 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
30	Depreciation			12,535	12,535		12,535	34,229	46,764			30
31	Amortization of Pre-Op. & Org.							668	668			31
32	Interest			504	504		504	87,886	88,390			32
33	Real Estate Taxes			77,681	77,681	46	77,727		77,727			33
34	Rent-Facility & Grounds			170,375	170,375		170,375	(170,375)				34
35	Rent-Equipment & Vehicles			11,102	11,102		11,102		11,102			35
36	Other (specify):*			3,127	3,127		3,127	(3,127)				36
37	TOTAL Ownership			275,324	275,324	46	275,370	(50,719)	224,651			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		4,486	8,415	12,901		12,901		12,901			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,254	25,254		25,254		25,254			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		4,486	33,669	38,155		38,155		38,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	987,134	220,666	607,522	1,815,322		1,815,322	(77,071)	1,738,251			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	306	30		9
10	Interest and Other Investment Income	(3,159)	32		10
11	Discounts, Allowances, Rebates & Refunds	(335)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(239)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(55)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,324)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,055)	21		28
29	Other-Attach Schedule	(11,641)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,502)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(41,569)	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,569)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (77,071)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
PARK RIDGE CARE CENTER

Page 5A

Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$ 1,838	6 1
2	FRANCHISE TAX	(250)	20 2
3	STATE REPLACEMENT TAX	(1,071)	21 3
4	TAXES-INCOME (BUILDING PARTNERSHIP)	(572)	21 4
5	TRUST FEES (BUILDING PARTNERSHIP)	(200)	21 5
6	LEGAL	(282)	19 6
7	SEMINAR	(75)	24 7
8	IL COUNCIL ON LTC COPE CONTRIBUTION	(79)	20 8
9	PRIOR-ANCILLARY THERAPIES	(2,590)	10A 9
10	PRIOR-MEDICAL SUPPLIES	(1,139)	10 10
11	PRIOR-FOOD	(1,719)	2 11
12	APARTMENT RENT	(2,375)	34 12
13	LOSS ON SALE OF ASSET	(3,127)	36 13
14			14
15			15
16			16
17			17
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85			85
86			86
87			87
88			88
89			89
90	Total	(11,641)	90

Summary A

12/31/00

12/31/00

[illegible]

Summary B

12/31/00

Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
D. Ownership													
Depreciation	306	33,923										34,229	30
Amortization of Pre-Op. & Org.		668										668	31
Interest	(3,159)	91,045										87,886	32
Real Estate Taxes													33
Rent-Facility & Grounds	(2,375)	(168,000)										(170,375)	34
Rent-Equipment & Vehicles													35
Other (specify):*	(3,127)											(3,127)	36
TOTAL Ownership	(8,355)	(42,364)										(50,719)	37
Ancillary Expense													
E. Special Cost Centers													
Medically Necessary Transportation													38
Ancillary Service Centers													39
Barber and Beauty Shops													40
Coffee and Gift Shops													41
Provider Participation Fee													42
Other (specify):*													43
TOTAL Special Cost Centers													44
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(35,502)	(41,569)										(77,071)	45

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LEO MAUER	25.00%	NONE		665 BUSSE HWY	PARK RIDGE	BUILDING CO
FREDA MAUER	25.00%					
JOSEPH MAUER	25.00%					
SHERRY MAUER	25.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENTAL INCOME	\$ 168,000	665 BUSSE HIGHWAY LTD PARTNERSHIP	100.00%	\$	\$ (168,000)	1
2	V	32 INTEREST INCOME	1,171	665 BUSSE HIGHWAY LTD PARTNERSHIP	100.00%		(1,171)	2
3	V	31 AMORTIZATION		665 BUSSE HIGHWAY LTD PARTNERSHIP	100.00%	668	668	3
4	V	30 DEPRECIATION		665 BUSSE HIGHWAY LTD PARTNERSHIP	100.00%	33,923	33,923	4
5	V	32 INTEREST		665 BUSSE HIGHWAY LTD PARTNERSHIP	100.00%	92,216	92,216	5
6	V	21 TAXES-INCOME		665 BUSSE HIGHWAY LTD PARTNERSHIP	100.00%	572	572	6
7	V	21 TRUST FEES		665 BUSSE HIGHWAY LTD PARTNERSHIP	100.00%	200	200	7
8	V	21 BANK CHARGES		665 BUSSE HIGHWAY LTD PARTNERSHIP	100.00%	23	23	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 169,171			\$ 127,602	\$ * (41,569)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V						\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V						\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V						\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PARK RIDGE CARE CENTER** # **0039255** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHERRY MAUER	ADMINISTRATOR	ADMIN	25.00%	0	50	100.00%	SALARY	\$ 70,124	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 70,124		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number PARK RIDGE CARE CENTER# 0039255

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PARK RIDGE CARE CENTER# 0039255

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PARK RIDGE CARE CENTER# 0039255

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00Ending: **12/31/00**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

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Phone Number () _____

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1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	HARRIS TRUST & SAVINGS		X	MORTGAGE			\$	1,268,559			\$	92,216	1	
2	LEASE ACCEPTANCE CORP		X	CAPITALIZED LEASE								505	2	
3													3	
4													4	
5													5	
	Working Capital													
6	INTEREST INCOME											(1,172)	6	
7	INTEREST INCOME											(3,159)	7	
8													8	
9	TOTAL Facility Related						\$	1,268,559				\$	88,390	9
	B. Non-Facility Related*													
10	Supplemental Schedule												10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$		14
15	TOTALS (line 9+line14)						\$	1,268,559				\$	88,390	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number

PARK RIDGE CARE CENTER

0039255

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	80,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	77,681	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(2,319)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	80,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	46	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>92</u> For 19 <u>94</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	77,727	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	70,875	8
	1996	72,234	9
	1997	78,135	10
	1998	75,966	11
	1999	77,681	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON 103% OF THE PRIOR YEAR REAL ESTATE TAX BILL.

THE 1994 REAL ESTATE TAX REFUND HAS NOT BEEN OFFSET IN THE CURRENT YEAR SINCE THE 1994 REAL ESTATE TAX BILL WAS NOT USED TO SET A RATE.

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number PARK RIDGE CARE CENTER# 0039255

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:A. Square Feet: 13,000 B. General Construction Type: Exterior BRICK Frame STEEL STUD Number of Stories 1C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONEF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: 3,441 2. Number of Years Over Which it is Being Amortized: 5 YEARS3. Current Period Amortization: 668 4. Dates Incurred: 12/93Nature of Costs: DEFERRED LOAN COST

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>			\$ <u>49,000</u>	1
2					2
3	TOTALS			\$ <u>49,000</u>	3

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	46		1993	1986	\$ 1,323,000	\$ 33,923	39	\$ 33,923	\$	\$ 238,877	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1994		8,310	213	20	416	203	1,796	9
10	Various		1995		33,691	864	20	1,685	821	6,381	10
11	WINDOW WORK		1997		586	16	20	31	15	86	11
12	REMODELING		1997		20,240	518	20	1,010	492	2,775	12
13	JACKING PLATES		1997		720	18	20	36	18	125	13
14	WATER HEATER		1998		3,988	102	20	199	97	496	14
15	SEALCOAT PKG LOT		1998		1,476	38	20	74	36	197	15
16	COMPRESSOR/MOTOR		1998		5,980	153	20	300	147	660	16
17	CUBICLE CURTAINS		1998		1,038	27	20	52	25	112	17
18	SECURITY SYSTEM		1998		6,411	164	20	601	157	649	18
19	AIR CLEANER		1999		2,791		20	140	140	222	19
20	HTG & A/C UNITS		1999		2,412	84	20	121	37	151	20
21	HTG & A/C UNIT		1999		830		20	42	42	67	21
22	AIR CLEANER		1999		1,494		20	75	75	113	22
23	GENERATOR		2000		1,653	16	20	16		16	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	PAGE 12A TOTALS				69,295	844		1,787	943	1,787	35
36	TOTAL (lines 4 thru 35)				\$ 1,483,915	\$ 36,980		\$ 40,508	\$ 3,248	\$ 254,510	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WINDOWS			2000	13,403	178	20	375	197	375	9
10	GENERATOR INSTALL			2000	7,942	77	20	165	88	165	10
11	AIR CONDITIONER			2000	757	10	20	22	12	22	11
12	PORTABLE GENERATOR			2000	2,625	25	20	55	30	55	12
13	REAR ENTRANCE RAMP			2000	2,350	18	20	39	21	39	13
14	RAMP RAILINGS			2000	650	4	20	8	4	8	14
15	SECURITY SYSTEM			2000	12,279	170	20	356	186	356	15
16	ADDITIONAL SECURITY SYSTEM			2000	9,155	128	20	269	141	269	16
17	CONDENSER			2000	9,420	131	20	275	144	275	17
18	GENERATOR			2000	10,714	103	20	223	120	223	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 69,295	\$ 844		\$ 1,787	\$ 943	\$ 1,787	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
9	Improvement Type**									9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
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18												
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26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
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28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
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26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
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25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
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29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
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27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
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25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
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25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 55,456	\$ 5,819	\$ 5,855	\$ 36		\$ 28,848	37
38	Current Year Purchases	3,251	3,251	210	(3,041)		210	38
39	Fully Depreciated Assets	99,923	128	191	63		99,923	39
40								40
41	TOTALS	\$ 158,630	\$ 9,198	\$ 6,256	\$ (2,942)		\$ 128,981	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,691,545	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 46,178	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 46,764	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 306	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 383,491	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

PARK RIDGE CARE CENTER
0039255
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
PARK RIDGE CARE CENTER, LTD	55,456	5,819	5,855	36	28,848
665 BUSSE HIGHWAY LTD PARTNERSHIP					
TOTALS	55,456	5,819	5,855	36	28,848

LINE 29: CURRENT YEAR

PARK RIDGE CARE CENTER, LTD	3,251	3,251	210	(3,041)	210
665 BUSSE HIGHWAY LTD PARTNERSHIP					
TOTALS	3,251	3,251	210	(3,041)	210

LINE 30: FULLY DEPRECIATED

PARK RIDGE CARE CENTER, LTD	1,923	128	191	63	1,923
665 BUSSE HIGHWAY LTD PARTNERSHIP	98,000				98,000
TOTALS	99,923	128	191	63	99,923

TOTALS (Should Tie to Totals on Page 13)

PARK RIDGE CARE CENTER, LTD	60,630	9,198	6,256	(2,942)	30,981
665 BUSSE HIGHWAY LTD PARTNERSHIP	98,000				98,000
TOTALS	158,630	9,198	6,256	(2,942)	128,981

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**

Report Period Beginning:

01/01/00Ending: **12/31/00****XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☒ YES☐ NO16. Rental Amount for movable equipment: \$ **2,247**Description: **OXYGEN CONCENTRATORS**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1999 NISSAN MAXIMA	\$ 379.00	\$ 2,274	17
18	FACILITY	2000 CHRYSLER LHS	\$ 509.00	\$ 6,581	18
19					19
20					20
21	TOTAL		\$ 888.00	\$ 8,855	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number

PARK RIDGE CARE CENTER

#

0039255

Report Period Beginning:

01/01/00

Ending:

12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
			1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 3,253	
2	Licensed Speech and Language Development Therapist	39-3	hrs			371			371	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			4,791			4,791	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				3,034		3,034	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**						1,452		1,452	13
14	TOTAL			\$		\$ 8,415	\$ 4,486		\$ 12,901	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 MEDICAL SUPPLIES-MEDICARE	569
2 RADIOLOGY-PART B	228
3 LABORATORY-MEDICARE	349
4 LABORATORY-MEDICAID	306
5	
6	
7	
8	
9	
10	
	<u>1,452</u>

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u> </u>
	<u> </u>

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 63,112	\$ 107,623	1
2	Cash-Patient Deposits	9,189	9,189	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	384,657	384,657	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,096	16,096	6
7	Other Prepaid Expenses	1,587	1,587	7
8	Accounts Receivable (owners or related parties)	200	231,853	8
9	Other(specify): See supplemental schedule	56,723	57,751	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 531,564	\$ 808,756	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		49,000	13
14	Buildings, at Historical Cost		1,323,000	14
15	Leasehold Improvements, at Historical Cos	134,692	134,692	15
16	Equipment, at Historical Cost	68,157	166,157	16
17	Accumulated Depreciation (book methods)	(66,759)	(403,636)	17
18	Deferred Charges		1,999	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	825	825	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 136,915	\$ 1,272,037	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 668,479	\$ 2,080,793	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 63,542	\$ 63,542	26
27	Officer's Accounts Payable	32,500	32,500	27
28	Accounts Payable-Patient Deposits	9,189	9,189	28
29	Short-Term Notes Payable	15,928		29
30	Accrued Salaries Payable	61,403	61,403	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,147	2,147	31
32	Accrued Real Estate Taxes(Sch.IX-B)	80,000	80,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation	76,886	76,886	34
35	Federal and State Income Taxes	2,716	2,716	35
	Other Current Liabilities(specify):			
36	See supplemental schedule		56,914	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 344,311	\$ 385,297	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,268,559	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,268,559	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 344,311	\$ 1,653,856	46
47	TOTAL EQUITY (page 18, line 24)	\$ 324,168	\$ #REF!	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 668,479	\$ #REF!	48

*(See instructions.)

12/31/00

As of 12/31/00

OTHER CURRENT ASSETS:	<u>Amount</u>	<u>Amount</u>	OTHER CURRENT LIABILITIES:	<u>Amount</u>	<u>Amount</u>
REAL ESTATE ESCROW DEPOSIT	56,723		DUE TO PARK RIDGE BLDG CO		191
LOANS & EXCHANGES		1,028			
	<u>56,723</u>	<u>1,028</u>		<u></u>	<u>191</u>
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
SECURITY DEPOSIT	825	825			
	<u>825</u>	<u>825</u>		<u></u>	<u></u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 313,166	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 313,166	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,252	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(60,250)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 11,002	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 324,168	24

* This must agree with page 17, line 47.

Facility Name & ID Number	PARK RIDGE CARE CENTER	#	0039255	Report Period Beginning:	01/01/00	Ending:	12/31/00
---------------------------	------------------------	---	---------	--------------------------	----------	---------	----------

Balance per General Ledger	313,166
----------------------------	---------

Adjustments:

-
-
-

Total adjustments

-

Balance - Beginning of Year

313,166

Equity(Deficit) from Page 17 Col 1

324,168

Related Party

Equity(Deficit)

Income

61200

41569

102,769

Combined Equity - End of Year

426,937

Facility Name & ID Number PARK RIDGE CARE CENTER

0039255

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,832,318	1
2	Discounts and Allowances for all Levels	21,148	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,853,466	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	20,933	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 20,933	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,551	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	443	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,138	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,132	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,159	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,159	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,884	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,884	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,886,574	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	432,846	31
32	Health Care	674,888	32
33	General Administration	394,109	33
	B. Capital Expense		
34	Ownership	275,324	34
	C. Ancillary Expense		
35	Special Cost Centers	12,901	35
36	Provider Participation Fee	25,254	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,815,322	40
41	Income before Income Taxes (line 30 minus line 40)**	71,252	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 71,252	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 OVERPAYMENT OF EMPLOYEE LOAN	50
2 CASH RECEIPT OF DONATION FOR EMPLOYEE BENEFIT	500
3 FIXED ASSET DISPOSITION	100
4 1994 REAL ESTATE TAX REFUND	92
5 OTHER SERVICES-PRIVATE	1,807
6 DISCOUNTS	335
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	2,884

Facility Name & ID Number **PARK RIDGE CARE CENTER**

0039255

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing	2,215	2,404	\$ 56,004	\$ 23.30	1
2 Assistant Director of Nursing					2
3 Registered Nurses	6,998	7,383	155,469	21.06	3
4 Licensed Practical Nurses					4
5 Nurse Aides & Orderlies	32,698	33,781	365,169	10.81	5
6 Nurse Aide Trainees					6
7 Licensed Therapist					7
8 Rehab/Therapy Aides					8
9 Activity Director					9
10 Activity Assistants					10
11 Social Service Workers					11
12 Dietician	753	847	12,466	14.72	12
13 Food Service Supervisor					13
14 Head Cook	563	685	8,484	12.39	14
15 Cook Helpers/Assistants	10,432	10,855	122,059	11.24	15
16 Dishwashers					16
17 Maintenance Workers	1,984	2,097	32,227	15.37	17
18 Housekeepers	7,808	8,435	71,623	8.49	18
19 Laundry	2,199	2,358	20,721	8.79	19
20 Administrator	2,176	2,287	70,124	30.66	20
21 Assistant Administrator					21
22 Other Administrative					22
23 Office Manager					23
24 Clerical	4,560	4,688	72,788	15.53	24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)					28
29 Resident Services Coordinator					29
30 Habilitation Aides (DD Homes)					30
31 Medical Records					31
32 Other Health Care(specify)					32
33 Other(specify)	0	0	0		33
34 TOTAL (lines 1 - 33)	72,386	75,820	\$ 987,134 *	\$ 13.02	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant		\$ 180	1-3	35
36 Medical Director	MONTHLY	6,150	9-3	36
37 Medical Records Consultant	51	3,315	10-3	37
38 Nurse Consultant				38
39 Pharmacist Consultant	MONTHLY	1,380	10-3	39
40 Physical Therapy Consultant	MONTHLY	448	10A-3	40
41 Occupational Therapy Consultant				41
42 Respiratory Therapy Consultant				42
43 Speech Therapy Consultant				43
44 Activity Consultant	MONTHLY	1,000	11-3	44
45 Social Service Consultant	MONTHLY	3,588	12-3	45
46 Other(specify)				46
47				47
48				48
49 TOTAL (lines 35 - 48)	51	\$ 16,061		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses	261	\$ 11,476	10-3	50
51 Licensed Practical Nurses	154	7,031	10-3	51
52 Nurse Aides				52
53 TOTAL (lines 50 - 52)	415	\$ 18,507		53

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		\$	\$
0	0	\$ 0	#DIV/0!

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT & DECORATING	1996	\$ 4,353	3	\$ 1,451	\$ 1,451	\$ 725	\$	\$	\$	\$	\$	\$
2	PAINT & DECORATING	1997	7,147	3	1,191	2,382	2,382	1,191					
3	PAINT & DECORATING	1998	1,940	3		323	647	647	323				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 13,440		\$ 2,642	\$ 4,156	\$ 3,754	\$ 1,838	\$ 323	\$	\$	\$	\$

Facility Name & ID Number **PARK RIDGE CARE CENTER**# **0039255**Report Period Beginning: **01/01/00**Ending: **12/31/00****XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LTC=\$1,803
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,192 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 25,254
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 564 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw